**A: 40 Colney Hatch Lane, London, N10 1DU**

**T: 020 8883 8214**

**F: 0844 815 1498**

**E:** **Rutlandhouse.surgery@nhs.net**

**CHILDREN (UNDER 16 YEARS OLD)**

**Confidential New Patient Registration Questionnaire**

|  |  |
| --- | --- |
| **Surname:** | **First Name(s):** |
| **Date Of Birth:** | **Gender: [ ]** Male **[ ]** Female |
| **Address:**  | **Home Telephone:** |
| **Mobile Telephone:** |
| **Consent to receive text messages via mobile re. child: [ ]** Yes **[ ]** No |
| **Place Of Birth:** | **NHS Number:** |
| **Emergency Contact Name and Number:** | **Previous GP Details (*GP Name, Practice Name & Practice Address*):**  |
| **Parent(s) Carer Name:**  |
| **School/Nursery Name:** | **School/Nursery Address:** |

**Please indicate your ethnicity**

[ ]  British or mixed British

[ ]  Irish

[ ]  Other White background

[ ]  White & Black African

[ ]  White & Asian

[ ]  Other Mixed background

[ ]  Indian or British Indian

[ ]  Pakistani or British Pakistani

[ ]  Bangladeshi or British Bangladeshi

[ ]  Other Asian background

[ ]  Caribbean

[ ]  African

[ ]  Other Black background

[ ]  Chinese

[ ]  Other

[ ]  Ethnic category not stated, *please state ethnicity……………………………………………………..*

**What is your first language?..............................................................................................................**

**CHILD’S MEDICAL HISTORY**

**Has your child had any of the following illnesses:**

|  |  |  |
| --- | --- | --- |
| [ ]  Measles | [ ]  German Measles | [ ]  Whooping Cough |
| [ ]  Asthma | [ ]  Chickenpox |  |
| [ ]  Mumps | [ ]  Fits |  |

**Has your child had any hospital admissions for serious illnesses or accidents?**

[ ]  Yes

[ ]  No

**Is there a history of fits/epilepsy in child’s parents/brothers/sisters?**

**…………………………………………………………………………………………………………………………………………..**

**…………………………………………………………………………………………………………………………………………..**

* **Due to Child Protection guidelines, children will not be registered without a parent/legal guardian also being registered at the practice.**
* **A birth certificate may be asked for to confirm who has parental responsibility for a child.**

**Please confirm name/s of person/s with parental responsibility for registering child:**

**…………………………………………………………………………………………………………………………………………..**

**Do you consent for another adult (grandparent, au pair) to seek medical advice/treatment for your child?**

[ ]  Yes

[ ]  No

**If yes, please provide the names of persons to whom this consent applies and relationship to child**

**…………………………………………………………………………………………………………………………………………..**

**SIGNATURE OF PARENT/LEGAL GUARDIAN: ………………………………………………………………………………..**

**NAME OF PARENT/LEGAL GUARDIAN: ………………………………………………………………………………………..**

**DATE: …………………………………………………………………………………………………………………………………**

**WE REQUIRE AN UP TO DATE IMMUNISATION HISTORY OF CHILDREN UP TO THE AGE OF 5 UPON REGISTRATION**

**PLEASE BRING YOUR RED BOOK TO THE SURGERY**